PRINTED: 02/06/2014 FORM APPROVED

(X3) DATE SURVEY

Kansas Department on Aging

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
		N087076	B. WING		01/28/2014			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE			
S 000	INITIAL COMMENTS		S 000					
		s represent the findings of a compliance revisit, and n #71552.						
S1364 SS=D	26-40-305 (3) P E - E	lectrical requirements	S1364					
		cuit to fixed or portable erapy units shall have a errupter.						
	by: The facility census tot observation and interv maintain the hydrocul	is not met as evidenced raled 58 residents. Based on view, the facility failed to ator (device containing hot) on a ground fault circuit let.						
	Findings included:							
	the hydroculator was	5/14 at 1:40 p.m. revealed located in a locked room in nt and the cord not plugged						
	9:32 a.m. revealed he	nance staff FF on 1/23/14 at s/she knew the hydroculator cked door and confirmed it utlet.						
	1/23/14 at 8:25 a.m. r	strative nursing staff A on evealed he/she knew the to be on a GFCI outlet and surprised it was not.						
	The facility failed to purply hydroculator.	rovide a policy regarding the						
	The facility failed to en	nsure the hydroculator						

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		N087076	B. WING		01/	/28/2014					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
AVITA HEALTH AND REHAB AT REEDS COVE WICHITA, KS 67228											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (C)						
S1364	Continued From page 1		S1364								
	plugged into a GFCI outlet.										